NAIC/CONSUMER LIAISON COMMITTEE

NAIC/Consumer Liaison Committee April 8, 2019, Minutes
NAIC/American Indian and Alaska Native Liaison Committee April 7, 2019, Minutes

Draft Pending Adoption

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NAIC/Consumer Liaison Committee
Orlando, Florida
April 8, 2019

The NAIC/Consumer Liaison Committee met in Orlando, FL, April 8, 2019. The following Committee members participated: Stephen C. Taylor, Chair (DC); Michael Conway, Vice Chair (CO); Lori K. Wing-Heier (AK); Jim L. Ridling represented by Mark Fowler (AL); Ricardo Lara and Lucy Jabourian (CA); Andrew N. Mais represented by Kurt Swan (CT); Trinidad Navarro (DE); David Altmaier (FL); Jim Beck (GA); Dean L. Cameron represented by Elaine Mellon (ID); Stephen W. Robertson represented by Karl Knable (IN); Vicki Schmidt (KS): Nancy G. Atkins represented by Josh Rayborn (KY); James J. Donelon represented by Ron Henderson (LA); Al Redmer Jr. represented by Nour Benchaaboun (MD); Steve Kelley represented by Peter Brickwedde (MN); Chlora Lindley-Myers (MO); Mike Causey represented by Tracy Biehn (NC); Bruce R. Ramge (NE); John G. Franchini represented by Paige Duhamel (NM); Barbara D. Richardson represented by David Cassetty (NV); Linda A. Lacewell represented by Troy Oechsner (NY); Jillian Froment represented by Jana Jarrett (OH); Jessica Altman (PA); Kent Sullivan represented by Leah Gillum (TX); Todd E. Kiser represented by Nancy Askerlund (UT); Scott A. White represented by Donald Beatty (VA); Mike Kreidler represented by Jane Beyer (WA); Mark Afable (WI); and James A. Dodrill (WV).

1. Heard Introductory Remarks of Chair

Commissioner Taylor welcomed the twelve regulator and consumer members of the 2019 NAIC Consumer Participation Board of Trustees (Board). He also welcomed the thirty-four 2019 consumer representatives, who were selected by the 2018 Board to present the consumer perspective at NAIC meetings. Commissioner Taylor, who is also the Board chair, said the Board finalized its revisions to the Plan of Operation for the NAIC Consumer Participation Program (Program) when it met earlier. He said the revised document would go to the Executive Committee for its consideration at a future meeting. He also said the Board met in closed session because the administration of the Program may require discussions of a confidential nature concerning personal information.

2. Adopted its 2018 Fall National Meeting Minutes

Commissioner Dodrill made a motion, seconded by Commissioner Conway, to adopt the Committee's Nov. 17, 2018, minutes (*see NAIC Proceedings – Fall 2018, NAIC/Consumer Liaison Committee*). The motion passed unanimously.

3. Heard a Presentation on the Persistent Problem of Unintended Underinsurance

Amy Bach (United Policyholders—UP) said Kenneth S. Klein is the Louis and Hermione Brown Professor of Law at California Western School of Law. She said he is also a fire survivor who lost his home in the 2003 Cedar Fire, and he is the recipient of the State Bar of California's 2008 President's Pro Bono Service Award for his work with survivors of natural disasters. She said he has worked pro bono with hundreds of disaster survivors across the nation on the entire array of insurance issues that can arise, as well as consulted with insurance professionals, state insurance regulators, legislators, and attorneys over the last 15 years. She said he has published numerous pieces on these issues ranging from opinion editorials in the *Los Angeles Times* to scholarly research in the *Connecticut Insurance Law Journal*.

Ms. Bach said UP is conducting "Road to Recovery" surveys six, 12 and 24 months after a fire disaster as an outreach to all impacted households. She said survey results indicate that over two-thirds of households did not think they had enough insurance to replace or rebuild their homes following a disaster, which means those households were underinsured. She said underinsurance means the policy has limits below replacement cost and protection gaps exist due to actual cash value (ACV), which is calculated by subtracting depreciation from replacement cost, only payouts on roofs; high deductibles; and unexpected exclusions or limitations regarding mold, water damage, and building code compliance. She said California solutions attempted to date include the legislature twice mandating standardized disclosures of ACV, replacement cash value (RCV), and guaranteed replacement cost (GRC) differences with insurance regulations saying if a carrier estimates RCV at point of sale, it must include enumerated features. She said policyholders still have a duty to select the coverage limits that are right for their needs; however, she also said homeowners should be able to rely on insurance they buy as a safety net in case of total losses. She said the CA Ins. Code at Section 10103.4, which is effective July 1, 2019, states:

> (a) An insurer that provides replacement cost coverage...shall, on an every other year basis, at the time an offer to renew a policy of residential property insurance is made to the policyholder, provide an estimate of the cost necessary

to rebuild or replace the insured structure that complies with Sections 2695.180 to 2695.183, inclusive, of Article 1.3 of Subchapter 7.5 of Chapter 5 of Title 10 of the California Code of Regulations. The estimate shall include:

(1) Cost of labor, building materials and supplies;
(2) Overhead and profit;
(3) Cost of demolition and debris removal;
(4) Cost of permits and architect's plans; and
(5) Consideration of components and features of the insured structure, including at least the following:
(A) Type of foundation;
(B) Type of frame;
(C) Roofing materials and type of roof;
(D) Siding materials and type of siding;
(E) Whether the structure is located on a slope;
(F) The square footage of the living space;
(G) Geographic location of property;
(H) Number of stories and any nonstandard wall heights;
(I) Materials used in, and generic types of, interior features and finishes, such as, where applicable, the type of heating and air conditioning system, walls, flooring, ceiling, fireplaces, kitchen, and bath(s);
(J) Age of the structure or the year it was built; and
(K) Size and type of attached garage.

(b) The estimate of replacement cost shall be based on an estimate of the cost to rebuild or replace the structure considering the cost to reconstruct the single property being evaluated, as compared to the cost to build multiple, or tract, dwellings.

Mr. Klein said he was fully insured when his house burned to the ground in 2003, but most of his neighbors who thought their homes were fully covered for replacement value discovered after the fact that they were not. He said all homeowners intend to have full coverage; however, industry statistics indicate that well over two-thirds are underinsured. He quoted Jay M. Feinman in his book, *Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It*, as saying, "96 percent of homeowners carry insurance." He said the prevalence and problem of underinsurance is far more encompassing than just a natural disaster or wildfire problem. He said the frequency of an owner-occupied home not having insurance is trivial, and Professor Feinman's conclusion is in intuitive harmony with data collected from the U.S. Census Bureau. He said according to the 2015 Housing Survey, of the 56 million owner-occupied homeowners reporting how their purchase or construction was financed, all but 16 million had a down payment of 20% or less. In other words, he said by the terms of their mortgages, slightly over 70% of all mortgaged homes were required, at the time of purchase or construction, to have insurance of at least 80% of the purchase or construction price. He said in 2015, over 60% of all owner-occupied homes with a mortgage had property insurance as part of the monthly mortgage payment. He said two economists—Benjamin L. Collier and Marc A. Ragin—wrote in their research paper, *The Influence of Sellers on Contract Choice: Evidence from Flood*, that among homeowners who were required to insure; were offered identical insurance products; and had the option to insure to value (ITV), over-insure, or underinsure, 80% were ITV or over-insured. He said the finding is in harmony with intuitive understandings of consumer purchases of homeowner insurance, since: 1) by operation of co-insurance clauses, there is a penalty to less than 80% ITV; 2) the margin of increased premium to move from 80% to 100% is small; and 3) a consumer can be penalized for making small claims, so the consumer is financially incentivized to express price elasticity through increased deductibles, rather than decreased coverage limits.

Mr. Klein said the underwriting exercise of predicting rebuild costs in the future is an art as much as a science and one would expect errors to occur equally high and low, in other words, a roughly equal incidence and depth of over-insurance and underinsurance, but he said that is not what is seen. He said the persistent finding over two decades is that almost always over 50% of homeowners are underinsured, and the problem is not improving over time. He said that is particularly troubling because, to an unknown frequency, homeowners will buy an endorsement extending their Coverage A by a fixed percentage ranging from 25% to 200%; therefore, if the cost estimating tools used to predict replacement cost are performing neutrally, the incidence of underinsurance probably should be less than 50% more often than not. He said this is what makes the green dot in the middle of the chart so interesting. He said that is a conclusion of the only study he could find of underinsurance of persons who had purchased endorsements extending Coverage A by a fixed percentage, and he said amongst this population (according to the study conducted by the California Department of Insurance), the incidence of underinsurance still was 57%. He said there is not a similarly robust data set modeling the depth of average underinsurance; the little information he found so far is consistent with, but not compelling of, the conclusion that across all homes, regions and demographics of the U.S., the average depth of underinsurance is at least 20%. He asked why this happens.

Mr. Klein said there is a country/western song lyric about the road to hell being paved with good intentions (Randy Travis, "Good Intentions," written by Merle Haggard, Randy Travis and Marvin Coe), and that seems to be what is happening here. He said homeowners want full RCV, homeowners are willing to pay for full RCV, insurers are willing to sell full RCV, insurers and homeowners appear to both think that the coverage in place is full RCV, and yet most homeowners are persistently and unwittingly materially underinsured. He said the reason that happens is that almost without exception, insurance companies employ component-based cost estimation software to identify recommended or required Coverage A coverage limits. He said these are database-driven tools that estimate the cost to rebuild a house down to its nuts and screws, using local wage rates and materials costs, periodically adjusting both for local fluctuation over time and the likelihood of particular addresses having a loss from a natural disaster resulting in a demand surge idiosyncratically driving cost. He said the two dominant vendors of these tools are Verisk Analytics and CoreLogic, who if their U.S. Securities and Exchange Commission (SEC) filings are correct, between them account for the Coverage A limits expressed in the vast majority of homeowner insurance policies. He said as a general matter, their tools can within an acceptable margin of error estimate actual rebuild costs, but he said that requires both time and expertise, because accuracy can quickly erode with insufficient, precise detail, such as the anticipated mitering of a kitchen countertop, which implicates both materials and labor costs. He said to get good estimates requires many hours of data input by a person with building contractor levels of expertise, and that is time and expertise in which no insurer (or insured) can or will invest. In order for Verisk Analytics and CoreLogic to be able to sell their product (their customers are insurers, not insureds), he said they must build in shortcut functions—the ability to get an estimate based on the answer to as few as two, three, or at least no more than a dozen questions without anyone debating that these shortcuts act as an exponential amplifier of error rates. While keeping this in mind, Mr. Klein said to remember the green dot from the previous slide. He said it suggests an important but unidentified error in the way component-based cost estimators calculate rebuild costs; therefore, what results is Coverage A coverage limits being calculated using tools purporting to accurately predict full RCV but which in fact repetitively understate those limits. He said that result is expressed to the state insurance departments through consumer complaints, especially but not entirely, in the wake of a mass loss event such as a tornado, hurricane or wildfire. He said the challenge is to simultaneously give insurers the business flexibility to be able to profitably price and promote risk, and yet, give consumers access to the full insurance that they need.

Mr. Klein said one solution is to allow insurers to price and promote risk however the insurer chooses, within the familiar regulatory guardrails of neither threatening the financial stability of the insurer nor constitute price gouging, but require that since the profit from error (over-insurance) is realized by the insurer, so too should the cost of error (underinsurance) be realized. In other words, he suggested having the responsibility for pricing error reside with the party with access to pricing information and control setting the price; but then, having done so, he suggested not letting the consumer avoid responsibility from an intentional underinsurance choice. He said a law or regulation that would do that might say:

> (a) For every policy of residential property insurance that is newly issued or renewed in this state, an insurer shall offer insurance for the full replacement of the insured property.
> (b) If the insured purchases the policy or renewal described in section (a), then, if the policy coverage limit is not enough to replace the insured property, the insurer shall be liable for the actual replacement cost.
> (c) If the insured does not purchase the policy or renewal described in section (a), then, if the policy coverage limit is not enough to replace the insured property, the insurer shall not be liable for the actual replacement cost.
> (d) This section shall not be deemed to limit or preclude an insurer and insured from agreeing to provide coverage for a policy limit that is lesser than the estimate of replacement value provided in accordance with subdivision (a).

Mr. Klein said legislation like this simply requires that every time an insurer quotes home insurance–either as a new policy or as a renewal—that the insurer price and quote a full replacement value option. If the customer opts to not buy that option, then that is on the consumer. If the customer does buy that option and Coverage A is inadequate, the policy is reformed to provide actual full RCV coverage. Mr. Klein said this solution gives the insurer full flexibility to price and promote its products as it chooses, while protecting the consumer from unintended, profound underinsurance; and it has the side advantages of dramatically reducing the frequency and costs of post-event legal disputes, which while bad for an attorneys business model, could be quite good for everyone else.

Commissioner Altmaier asked how the two-thirds of insureds know they are underinsured. Ms. Bach said the majority find out after a catastrophic loss has occurred.

Commissioner Beck asked if the studies indicated any consumer resistance to quoting full coverage. Ms. Bach said research indicated that consumer demand is for an instant electronic quote for all types of insurance and any delay in receiving it results in consumers moving on to a company from whom they can get an instant quote.

4. Heard a Presentation on Insurance Interference with the Performance of Automobile Repairs

Erica Eversman (Automotive Education & Policy Institute—AEPI) said vehicles are being put back on the road that are not safe because there are no federal or state law dictating safe repairs, no post-repair safety inspection, and no prohibition on dangerous techniques like "clipping." She said clipping is a term that is used when an automobile sustains front or rear-end damage in an accident; the damaged half is cut away and replaced by welding a new front or rear-end onto the damaged vehicle. She said it is a legal and safe way to repair damaged vehicles; however, welding is often not paid for by insurance companies, but using adhesive to glue the two halves of the damaged vehicle together is paid for by insurance companies. She said automotive repair shops then opt to use the type of repair that is paid for by insurance companies. However, no one notifies car owners that such repairs void their manufacturer's warranty.

Ms. Eversman said the AEPI has been advocating for 20 years to make it illegal to do this and referred to the photo of a clipped car seconds after its second accident. She said the car was split in half after being hit broadside—not by another car—but rather by a motorcycle. She said the 2017 case of *Seebachan v. John Eagle Collision* involved a Honda-certified repair facility that was an insurer "preferred collision repairer" or designated repair provider (DRP) shop that repaired a Honda Fit damaged in a hail storm in accordance with how the insurer would pay. She said the insurer would not pay for the original equipment manufacturer (OEM) standards required procedure of welding, so the car was repaired using "structural adhesive." She said an accident involving the same vehicle that occurred after such repairs caused life-threatening burns to a young couple riding in the car with the husband spending two years in a hospital, and the court awarded a $42 million verdict, in compensatory damages only, to the couple from the repair shop. She said the repair shop allowed insurer interests to override OEM judgement on proper, safe repair for a cheaper, cost-cutting method, and the Seebachans are suing the insurer.

Ms. Eversman said this was not an isolated incident, as insurers withhold payment routinely for necessary OEM mandated procedures affecting safety. She said there are no statistics to point to on how many deaths due to faulty repairs as the National Highway Traffic Safety Administration (NHTSA) does not collect data for the Fatality Analysis Reporting System (FARS) on prior vehicle damage or repair. She said the OEM requires both pre-vehicle scans, which can identify areas where necessary repairs are needed, and post-vehicle scans, which can confirm that necessary repairs have been made and that the vehicle is safe to return to the road. She said insurers routinely refuse one or both scans; and, the decision is determined on a case-by-case basis. She said failure to perform OEM procedures affecting safety can interfere with airbag deployment timing, render specialty high-strength steels brittle, or materially impair crumple zones of passenger compartments. She said national collision repair organizations that officially endorse the use of OEM procedures include the Society of Collision Repair Specialists (SCRS), the Automotive Service Association (ASA), Alliance of Automotive Service Providers (AASP), and the Assured Performance Network. She said OEM procedures are the industry standard and insurer estimates that state insurers pay to repair per "generally accepted industry standards," but many insurers refuse to pay for OEM safety-related procedures.

Ms. Eversman said the position of the Inter-Industry Conference on Auto Collision Repair (I-CAR) is to always follow vehicle maker procedures. She said I-CAR serves and is represented by all segments of the inter-industry, including collision repair, insurance, original equipment manufacturers, education, training, research, tools, equipment, supply, and related industry services. She said auto manufacturers, including the Alliance of Automotive Manufacturers and the Association of Global Automakers, globally endorse OEM procedures as repair industry standards. She said legislation for OEM procedures is pending in Connecticut, Illinois, Louisiana, Minnesota, Mississippi, Montana and New Hampshire. She said the current arbitration policy of the National Auto Auction Association (NAAA) states that the dealer must disclose in the Seller Disclosure Requirements section of the sales contract any structural repair not made per OEM guidelines.

5. Heard a Presentation on Insurers' Use of Criminal History Databases and Scores

Birny Birnbaum (Center for Economic Justice—CEJ) said advocates of algorithmic techniques like data mining argue that they eliminate human biases from the decision-making process. He said an algorithm is only as good as the data it works with and that data mining can inherit the prejudices of prior decision-makers or reflect the widespread biases that persist in society at large. He said the "patterns" it discovers are simply preexisting societal patterns of inequality and exclusion. He said unthinking reliance on data mining can deny members of vulnerable groups full participation in society. He said America's poor and working-class people have long been subject to invasive surveillance, midnight raids, and punitive public policy that increase the stigma and hardship of poverty. He said during the 19th century, these people were quarantined in county poorhouses; and during the 20th century, they were investigated by caseworkers and treated like criminals on trial. He said currently a digital poorhouse has been forged from databases, algorithms and risk models. He said it promises to eclipse the reach and repercussions of everything that came before. He said TransUnion (TU) recently evaluated the predictive power of court record violation data, including criminal and traffic violations. Also, as court records are created when the initial citation is issued, TU said they provide insight into violations beyond those that ultimately end up on the motor vehicle record (MVR), such as violation dismissals, violation downgrades, and pre-adjudicated or open tickets. Mr. Birnbaum asked what the likelihood is that TU criminal history scores have a disparate impact against African Americans. He then said to consider policing records in Ferguson, MO.

Mr. Birnbaum said the U.S. Department of Justice (DOJ) investigation of the Ferguson Police Department's (FPD) approach to law enforcement both reflects and reinforces racial bias, including stereotyping. He quoted the DOJ report as saying the harms of Ferguson's police and court practices are borne disproportionately by African Americans, and there is evidence that this is due in part to intentional discrimination based on race. The report also said Ferguson's law enforcement practices overwhelmingly impact African Americans. It said data collected by the FPD from 2012 to 2014 shows that African Americans account for 85% of vehicle stops, 90% of citations, and 93% of arrests made by FPD officers, despite comprising only 67% of Ferguson's population. The DOJ said the FPD appears to bring certain offenses almost exclusively against African Americans. For example, from 2011 to 2013, African Americans accounted for 95% of Manner of Walking in Roadway charges, and 94% of all Failure to Comply charges. This investigation indicates that this disproportionate burden on African Americans cannot be explained by any difference in the rate at which people of different races violate the law. Rather, the investigation has revealed that these disparities occur, at least in part, because of unlawful bias against and stereotypes about African Americans.

Mr. Birnbaum said algorithms based on data reflecting historical unfair discrimination will reflect and perpetuate that unfair discrimination. He said using such biased data in a computer model does not eliminate that unfair bias; i.e., it codifies that bias in the guise of an objective analysis. He said a sacred principle of the American criminal justice system is that a defendant is innocent until proven guilty. He said the 14th amendment to the U.S. Constitution guarantees every person due process and equal protection under the law. He said criminal history scores and databases sabotage these consumer rights and protections. He said the consumer protections in the federal Fair Credit Reporting Act (FCRA) permits insurers to utilize consumer reports provided by consumer reporting agencies for insurance underwriting. He also said consumer credit reports are examples of a consumer report. He said the FCRA requires critical consumer protections, including: 1) permission by the consumer to access and use the consumer report; 2) notification if an adverse action has resulted from the use of the consumer report; 3) an opportunity to obtain a copy of the consumer report; 4) an opportunity to correct an erroneous consumer report; and 5) an opportunity to request reconsideration based on a corrected consumer report.

Mr. Birnbaum said many databases marketed to insurers evade the consumer protections of the FCRA. One example is LexisNexis databases, which are not provided by consumer reporting agencies, as that term is defined in the FCRA, and does not constitute consumer reports, as that term is defined in the FCRA. Accordingly, he said this database may not be used in whole or in part as a factor in determining eligibility for credit, insurance, employment or another purpose in connection with which a consumer report may be used under the FCRA. Due to the nature of the origin of public record information, the public records and commercially available data sources used in reports may contain errors. Mr. Birnbaum said source data is sometimes reported or entered inaccurately, processed poorly or incorrectly, and is generally not free from defect. He said this product or service aggregates and reports data, as provided by the public records and commercially available data sources, and is not the source of the data, nor is it a comprehensive compilation of the data. He also said before relying on any data, it should be independently verified. He said consumer reports not subject to the FCRA and that do not need to comply with it are those that are not used for underwriting. He said the potential for unfair discrimination and biased algorithms reflecting and perpetuating historical discrimination exists for claims settlement and antifraud as much as for insurance pricing. He also said there is potential for improper use of non-FCRA databases for FCRA purposes; e.g., utilizing non-FCRA criminal history data for underwriting and pricing.

Mr. Birnbaum said algorithms reflect bias in data and bias in modelers. Considering data used in antifraud models, he said these models tap a variety of data sources to identify characteristics of the consumer and/or the claim correlated with a fraudulent or suspicious claim. He said *The Role of Data and Analytics in Insurance Fraud Detection* says, "Unstructured data has become an opportunity instead of a problem. Many insurers have the ability to change unstructured information into structured data and actively mine this for the opportunities available therein." It also says, "This [propensity] modelling is used to determine the likelihood of a new policy holder to commit a fraudulent act, and it can be done in real-time." and "Fraud detection has changed in its location relative to the insured. Insurers are now able to run predictive and entity analytics during multiple touch points, essentially as each new piece of information is added. This not only improves detection capabilities in the event of fraud, but it also allows an insurer to assess a fraud-risk. Some have begun providing risky policy holders with high-priced policies in order to drive them to other service providers."

Mr. Birnbaum said action needed by state insurance regulators to protect consumers regarding insurer's use of criminal history data would be to: 1) investigate by surveying insurers on the sources and uses of consumer's criminal history data and surveying purveyors of criminal history data and algorithms for the sources and uses of their products; 2) evaluate by identifying appropriate and inappropriate uses of criminal history data; 3) protect consumers and promote fair competition by requiring FCRA-type consumer protections and disparate impact analysis of uses and applications of criminal history data; and 4) establish an NAIC joint working group of the Market Regulation and Consumer Affairs (D) Committee and the Big Data (EX) Working Group to assist the states.

6.. Heard a Presentation on a "Deeper Dive" on Short-Term Health Plans

Justin Giovannelli (Georgetown University Center on Health Insurance Reforms—GUCHIR) said the GUCHIR published a study in January 2019 with support from the Robert Wood Johnson Foundation titled, *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses*. He said the goal of the study was to assess how short-term, limited duration insurers are marketing their products and determine if these tactics changed during the open enrollment period (OEP) for federal Affordable Care Act (ACA)-compliant coverage. He said eight states were studied during October and November 2018 (prior to and during the OEP) resulting in two separate reports: Colorado, Florida, Idaho, Maine, Minnesota, Missouri, Texas and Virginia. He said the studies were conducted using: 1) internet scans using search terms, such as cheap health insurance, short-term health insurance, Obamacare plans, and ACA enroll; 2) answering broker calls with a consumer profile of age 29, healthy and $20,000 yearly income; and 3) insurer website scans.

Eric Ellsworth (Consumers' Checkbook/Center for the Study of Services) said marketing for short-term products dominated search returns during the OEP. He said websites providing information about, or enrollment for, non-ACA-compliant products, including short-term plans, appeared four times as frequently during the OEP as did ACA-only sites. He also said prior to the OEP, this ratio was 77:1. He said marketing content encouraged consumers to consider short-term products as a replacement for ACA coverage and that this was the case both before and during the OEP. He said web searches pointed consumers to non-compliant products and provided little information to inform purchases. He said lead-generating websites were the most common search result in every state, comprising more than half of results before and during the OEP. He said lead-generators provide limited, if any, information about plan benefits, cost sharing or rates. He also said web brokers and issuers made available more information and plan details, but authors encountered no website that provided detailed policy documents, including a contract, prior to sale. He said several lead-generators used the OEP for ACA coverage as a marketing hook, but none directed consumers to *https://www.healthcare.gov*. He said brokers tried to make quick phone sales without providing written information. He said brokers did not provide information about the plan type (i.e., whether it was short-term coverage) unless asked, with half recommending non-compliant coverage to this subsidy-eligible consumer; and the two that did suggest an ACA plan, recommended that it be bundled with supplemental coverage products; and pressed the consumer for a quick purchase, but almost all refused, or failed, to provide written plan information when asked. He said as of March 2019, 24 states have some type of legislation about short-term limited duration insurance.

Sarah Lueck (Center on Budget and Policy Priorities) said results from in-depth interviews by the Kleimann Communication Group (Kleimann) testing consumers' understanding of short-term plans, which present a challenge to consumers, show that confused consumers do not understand the complex and limited nature of short-term products. She said these products are aggressively marketed to consumers as an alternative to ACA plans by not explaining that such products do not comply with ACA standards, in that they do not cover standard benefits, renewability or preexisting conditions. She said consumers may be stuck with very high out-of-pocket costs because disclosures intended to protect consumers depend on understanding complex concepts. She said the study goals used a marketing brochure for a six-month, best-selling short-term plan currently being marketed in seven states to assess consumers' use of plan brochures to determine if consumers understand the benefits, exclusions and other plan limits, and out-of-pocket costs. The methods used by Kleinmann were that nine of 10 participants, consisting of a mix of income, race and gender, were recruited—half with chronic conditions and half without chronic conditions—in St. Louis, MO. Ms. Lueck said in-depth interviews asked participants to read and discuss a plan brochure for a commonly-sold plan. She said key findings from this study found that consumers: 1) did not notice the federally-mandated disclosure; 2) made assumptions about what was covered based on the ACA framework—that maternity or prescription drugs would be covered; 3) struggled to understand limitations related to pre-existing conditions—thought such conditions would be covered; and 4) could not understand the plan's cost-sharing requirements or apply basic financial scenarios—such as using deductible and coinsurance.

Based on the study's findings, Ms. Lueck said their recommendations are that: 1) the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171) includes robust standards for short-term plans; 2) the Market Regulation and Consumer Affairs (D) Committee expedites approval of the short-term plan data call; and 3) state policymakers further regulate short-term plans.

7. Heard an Update on the Latest Recommendations from the USPSTF

Lucy Culp (American Heart Association) said the U.S. Preventive Services Task Force (USPSTF) develops recommendations for preventative services in the U.S. and provides updates annually to those recommendations. She said the USPSTF is an independent, volunteer panel of national experts that publishes evidence-based recommendations about clinical preventive services in an open and transparent process for updating recommendations that include ACA mandates that private insurance plans and Medicaid expansion programs cover under preventive services with a USPSTF A or B rating at no cost to the consumer. She said the plans must provide the preventive service without cost sharing beginning in the plan year that begins

at least one year following the final USPSTF recommendation. She said the latest update includes pre-exposure prophylaxis (PrEP) and new colorectal cancer screening guidelines.

Amy Killelea (National Alliance of State and Territorial AIDS Directors—NASTAD) said PrEP is a once-daily antiretroviral medication that prevents human immunodeficiency viruses (HIV). She said there is only one Food and Drug Administration (FDA) approved medication for PrEP right now, but more medications are in the pipeline. She said it is an incredibly effective, but underused, prevention tool with a small percentage of the 1.1 million Americans eligible for PrEP accessing it. She said increasing PrEP uptake features prominently in the new initiative from the Administration to end new HIV infections by 2030.

Luc Athayde-Rizzaro (National Center for Transgender Equality) said in November 2018, the USPSTF released a draft Grade A recommendation for PrEP that clinicians offer PrEP with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. He said anticipated implementation challenges include: 1) underwriting methods used in discriminatory or stigmatizing ways that could limit access to medication; 2) limiting access to PrEP services such as HIV, hepatitis, and sexually transmitted infections (STI) testing at initiation and every three months, as well as follow-up provider appointment every three months, all of which should be covered without cost sharing; 3) identifying individuals at high risk; and 4) accounting for different delivery systems for PrEP. He said recommendations for state insurance regulators are implementation guidance, monitoring and enforcement, which will be critical once the recommendation is final. He said state insurance regulators may also consider bulletins and other communications to make plans aware of the coverage, utilization review, and cost-sharing requirements. He said resources include: 1) the USPSTF draft recommendation for PrEP; 2) the Centers for Disease Control and Prevention (CDC), clinical practice guidelines for PrEP; 3) the Centers for Medicare & Medicaid Services (CMS), limitations on cost-sharing under the ACA frequently asked questions (FAQ); and 4) New York State Department of Financial Services, Insurance Circular Letter No. 21 (2017) that includes guidance for plans to cover PrEP and the reiteration of application of state non-discrimination requirements to PrEP coverage.

Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) said in 2018, the ACS updated its colorectal cancer screening guidelines and now recommends that adults aged 45 years and older with an average risk of colorectal cancer undergo regular screening with either a high-sensitivity, stool-based test or a structural exam (such as a colonoscopy), depending on patient preference and test availability. She said as a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with a timely colonoscopy, and more information on screening guidelines is available at *https://www.cancer.org*. She said existing state mandates are that some states require private insurers and/or state Medicaid programs to use ACS guidelines to inform colorectal cancer screening requirements (automatic), and some states consult ACS guidelines with those states requiring additional steps for a coverage change.

Having no further business, the NAIC/Consumer Liaison Committee adjourned.

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Orlando, Florida
April 7, 2019

The NAIC/American Indian and Alaska Native Liaison Committee met in Orlando, FL, April 7, 2019. The following Liaison Committee members participated: Michael Conway, Chair (CO); Lori K. Wing-Heier, Vice Chair (AK); Trinidad Navarro and Frank Pyle (DE); Dean L. Cameron represented by Elaine Mellon (ID); Matthew Rosendale represented by Bob Biskupiak (MT); Mike Causey represented by Tracy Biehn (NC); John G. Franchini represented by Paige Duhamel (NM); Glen Mulready represented by Courtney Khodabakhsh (OK); Andrew Stolfi (OR); Larry Deiter represented by Frank Marnell (SD); and Mike Kreidler (WA).

1. Adopted its 2018 Fall National Meeting Minutes

Director Wing-Heier made a motion, seconded by Ms. Biehn, to adopt the Liaison Committee's Nov. 16, 2018, minutes (*see NAIC Proceedings – Fall 2018, NAIC/Consumer Liaison Committee, Attachment One*). The motion passed unanimously.

2. Discussed the Rising Epidemic of Youth Suicide in American Indians and Alaska Natives

Commissioner Conway said, due to the cancellation by the speaker, a last-minute change was made to the agenda. He asked members to help lay the groundwork for the Liaison Committee to use in its approach to this problem so they could get more help to youth this year by discussing the issue of youth suicide in tribal communities, rather than hear a presentation.

Director Wing-Heier said the Liaison Committee would like to hash out the goals at this meeting, because there is no place for tribal kids, especially those in rural or isolated locations, to get any type of assistance when it is most desperately needed.

Mr. Biskupiak said the opioid issue is the leading cause of the rise in youth suicide in the American Indian population.

Commissioner Stolfi said state insurance regulators can and should do something, perhaps from an educational angle, in order to train physicians and first responders to learn how to spot the problem early.

Ms. Duhamel suggested insurance companies be asked to present to the Liaison Committee at future national meetings on how their company's case managers work with state insurance regulators on these issues.

Commissioner Conway said he approached one company about this issue at the National Congress of American Indians (NCAI) 75th Annual Convention and Marketplace in Denver, CO, in fall 2018 with this suggestion and was basically told to "pound sand"; i.e., the company was not interested in pursuing it.

Andrew Sperling (National Alliance on Mental Illness—NAMI) said suicide is the 10th leading cause of death in the U.S., with 47,000 deaths and 1.4 million attempts in 2018, representing a cost of $69 billion. He said 21.5% of those were for American Indians, which is three-and-a-half times higher than that of the total population.

Mr. Sperling said in the behavior health realm, the best evidence for preventing youth suicide can be found in proactive action. He said the national strategy for suicide prevention in 2018 was based, in the most part, on seven steps: 1) identification (training primary care physicians to recognize the signs of possible suicide attempts when young people are being seen for other conditions that may not be directly related to suicide); 2) risk assessment; 3) screening; 4) suicide care management; 5) removal of means (guns, drugs, etc.); 6) transition to warm (supportive contacts); and 7) improve policies and procedures.

Mr. Sperling said better engagement is needed with Indian Health Services (IHS) so front-line clinic staff can be trained to intervene with this suicide prevention protocol. He said the federal Mental Health Parity Act was a start, but that it needs a behavioral health care workforce to implement it fully. He said NAMI would be happy to help the NAIC with this endeavor, potentially through its family-to-family protocol.

Commissioner Conway said the Liaison Committee needs to be cognizant that American Indians are members of sovereign nations, but the Liaison Committee could possibly help tribes see what to do. He said becoming culturally aware is critical before any help is offered by the Liaison Committee.

Director Wing-Heier asked if telehealth programs would work in the more rural areas like Alaska.

Mr. Sperling said there is no behavioral health care available in villages, where follow-up contact is the most needed.

Ms. Duhamel suggested tribal communities do this type of follow-up themselves. She said there are some insurance companies started by tribes themselves, noting that the Liaison Committee could ask these companies how they are handling this issue.

Commissioner Kreidler said the U.S. Public Health Service Commissioned Corps might be able to help, noting that his office could provide a contact name. Mr. Sperling said he has the name of the assistant director of the U.S. Department of Health and Human Services (HHS).

Lisa Wilson (Centers for Medicare and Medicaid Services' Center for Consumer Information and Insurance Oversight—CCIIO) said she has formal working relationships with tribal leaders. She said the CCIIO works with tribal members on eligibility and how to get enrolled with special protection through health care exchanges. She said tribal members can get this type of help through IHS, even if they purchase coverage on the exchange. She said for tribal members to be eligible, they must demonstrate tribal membership through documentation, which can be obtained online or by postal mail. She said fact sheets and forms are available for monthly enrollment purposes in this ongoing work in Indian Country and that there are no copays nor deductibles. She said technical webinars and sample Summary of Benefits and Coverage (SBC) forms are available for zero cost-sharing plans.

Director Wing-Heier asked if there is any way an Alaska Native could continue to be enrolled year after year, rather than having to start and stop enrollment every year, especially when the premiums are paid for many tribal members as falling below the 300% of the poverty level.

Ms. Wilson said the CCIIO team often goes to Alaska corporations in order to do listening sessions and would investigate this question prior to the next trip.

3. Discussed the Removal of Tribal Health Resources from the U.S. Department of Health and Human Services (HHS) Website

Commissioner Conway said this topic is being reviewed by NAIC Legal Division staff and will be discussed further at the Summer National Meeting.

Director Wing-Heier said there is a lot of information included in the head table packet, which was distributed to Liaison Committee members and interested regulators for their review about this topic.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) said different agencies do separate pieces, so it is tough to lay responsibility for the lack of available care. She said schools have programs in special education classes and in regular education classes; state and federal dollars are used differently; accessibility is an issue for those with disabilities; there is a lack of sports programs, which help build confidence in young people; programs need to be available such as wheelchair basketball; finding a provider who looks like you if you are a disabled youth or a tribal youth; it is a basic cultural issue; education needs to be funded for American Indians and Alaska Natives to pursue behavior science as a career, then return to their tribes in order to help others.

Commissioner Conway agreed and said perhaps such care could be brought to the tribes now via telehealth or telemedicine.

Director Wing-Heier suggested something like Project ECHO (Extension for Community Healthcare Outcomes) be used for this purpose.

Ms. Duhamel said she has a close friend whose focus is on American Indian health care issues who is working with the American Speech-Language-Hearing Association and was recently asked to speak on audiology issues. She said she will ask her friend to present this report to the committee when the report is finished.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.

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